Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
JACK MITCHELL

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-1369-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 17, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In this FAX you will find that we have stated our position substantively for each claim or Date of Service that was not paid in full. If there is any other evidence that we feel is pertinent to this then we will also enclose. We will attempt to contact you to see if this matter can be resolved before sending this to Medical Dispute Resolution … The sender would at this time call attention to the Rule 133.304(1). Since all of the rules have been followed above that the carrier must within 21 days of receiving the request for reconsideration, the insurance carrier shall take final action on the medical bill as described in subsection(b) Rule 133.304.."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor, as designated doctor, conducted MMI and IR exams then billed Texas Mutual 99456-WP,W5, 99456-WP,W6, and 99456-WP,MI. Texas Mutual paid the requestor $650.00 for 99456-WP,W5; $500.00 for 99456-WP,W6; and $50 for 99456-WP, MI. However, the requestor insists on payment of additional $50.00 for code 99456-WP,MI."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2013	CPT Code 99456-WP-MI	$50.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the procedure for medical fee guideline for worker's compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - No explanation of benefits received

Issues

1. Did the requestor submit appropriate documentation for medical fee dispute resolution request?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307(c)(2)(M) states a copy of all applicable medical records related to the dates of service in dispute.

   Additionally, 28 Texas Administrative Code §134.204(j)(1) states The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include: (A) the examination; (B) consultation with the injured employee; (C) review of the records and films; (D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and, (E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Act and Division rules in Chapter 130 of this title (relating to Impairment and Supplemental Income Benefits).

   Review of submitted documentation finds no information and records related to the disputed service May 16, 2013 in the DWC-60 request received for performed services of maximum medical improvement and impairment rating examination.

   Therefore, the documentation provided is not supported as documentation does not include the examination, records, reports that are related to the maximum medical/impairment rating evaluation for disputed service May 16, 2013.
2. The respondent issued payment in the amount of $50.00. Based upon the documentation submitted, no additional reimbursement is recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		08/29/14
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.